Department of Health
Office of Emergency Medical Services & Trauma System

OUT-OF-STATE APPLICATION

Social Security Number
(Required under 42 USC 666 and Chapter 26.23 RCW)

Date of Birth
(mm/dd/yyyy)

Phone Number

Last Name

First Name

M.I.

Address, City, State, Zip Code *(Where you want your certification card to be sent)*

E-mail Address

Part 'A'

THE CERTIFICATION LEVEL I AM APPLYING FOR IS: *(Please Select One)*

☐ **First Responder** ☐ **EMT** ☐ **IV Tech** ☐ **Airway Tech** ☐ **IV/Airway Tech** ☐ **ILS Tech** ☐ **ILS W/Airway** ☐ **Paramedic**

Will you be *primarily* a "paid" or "volunteer" EMS provider? **PAID** ☐ **VOLUNTEER** ☐

CERTIFICATION REQUIREMENTS:

Part 'B'

		YES	NO
1.	Have you submitted the signed Washington State Specific Objectives Affirmation Statement for the level of certification you are seeking?	☐	☐
2.	Have you submitted a certificate of completion for the Washington State *"Infectious Disease Prevention for EMS Providers"* training (Revised October 1997) or a Washington State Department of Health approved 7 hour HIV/Aids training course?	☐	☐
3.	Have you attached a legible copy of your *current* state and/or NREMT certification card?	☐	☐
4.	Have you attached a legible copy of a *current* official picture identification card which also shows your date of birth (i.e., driver's license, passport, military ID, etc.)?	☐	☐
5.	Are you a high school graduate or have you earned a GED certificate?	☐	☐

EMS AGENCY ASSOCIATION REQUIREMENT:

Part 'C'

EMS AGENCY NAME:

Name: _____

Address: _____

Phone Number: _____

EMS Contact Person: _____

DOH Agency License Number: _____

FOR INTERNAL DOH OFFICE USE ONLY

State/NR Card ___ HIV Training ___ WSSO's ___ Exam ___ Part D ___ Photo ID ___ Conf Form ___ NR Verif ___ BC ___

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Part 'C'

If you are certified, will you continue to provide EMS care with the agency you identified on the front of your application? YES ☐ NO ☐ (Continued)

EMS AGENCY SUPERVISOR:

"I affirm that if this applicant is certified, he/she will provide care with our EMS agency."

Name of EMS Agency Supervisor (Please Print) | **Original Signature** | **Date**

MEDICAL PROGRAM DIRECTOR:

The signature of the Washington State Medical Program Director (MPD) for the county where the applicant is providing care, or where his/her EMS agency is based, is *required* before state certification may be granted to this applicant.

☐ "I ***recommend*** certification ☐ I ***do not recommend*** certification *(attach a memo for details)*

of this applicant based on the statements above, pending successful completion of the required examinations and/or evaluations. This applicant, if recommended for certification, has a copy of my county protocols."

MPD's Original Signature | **Date**

APPLICANT:

"I hereby affirm and declare that the information provided on this application is *true* and *correct*, and that any fraudulent entry may be considered sufficient cause for *rejection* or subsequent *revocation* of my certification. I further affirm that I have received a copy of the MPD's *protocols* for my level of certification."

Applicant's Original Signature | **Date**

NOTE: Pages 1 and 2 of this application is good for a period of one year from date the applicant signs the form.

RETURN COMPLETED APPLICATIONS TO:

Office of Emergency Medical Services & Trauma System
Licensing and Certification Section
PO Box 47853
Olympia, WA 98504-7853

1-800-458-5281, Ext. #1 or (360) 236-2845

Office of Emergency Medical Services and Trauma System website: ***www.doh.wa.gov/hsqa/emtp/***

RESET FORM PRINT FORM

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OUT-OF-STATE APPLICATION

Office of Emergency Medical Services and Trauma System

Part 'D' - Personal Information

C O N F I D E N T I A L

Certification of health care professionals is designed to protect the citizens of Washington State from unsafe health care. As part of the certification process, all applicants for certification are required to answer the same, legally defensible, personal data questions, narrowly focused to the fitness to practice the essential skills of this profession.

Part 'D' must be completed by all applicants and returned *directly* to the Department of Health to maintain confidentiality. Please follow the instructions below:

1. **Detach, review and complete this portion of the application. Make sure you provide *accurate* information.**
2. **Attach additional information (if appropriate), and mail it to the address shown on the bottom of Page 4.**

LAST NAME **FIRST NAME** **M.I.**

ADDRESS, CITY, STATE, ZIP CODE

SOCIAL SECURITY NUMBER
(Required under 42 USC 666 and Chapter 26.23 RCW)

COUNTY OF *PRIMARY* EMPLOYMENT

Yes **No**

1. Do you **currently** have a medical condition which **in any way impairs or limits your ability to provide EMS with reasonable skill and safety**? If *"yes",* please explain. ☐ ☐

   "Currently" means recently enough so that your medical condition may have an ongoing impact on your ability to function as an EMS provider, and includes at least the past two years.

   "Medical condition" includes physiological, mental or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered *"yes"* to question #1, please explain if, and how, the limitations or impairments caused by your medical condition are *reduced* or *eliminated* because you receive ongoing treatment. (Are you using medication to treat this condition? If so, please list).

   1b. If you answered *"yes"* to question #1, please explain if, and how, the limitations or impairments caused by your medical condition are *reduced* or *eliminated* because of your field of practice, the setting, or the manner in which you have chosen to practice.

If you answered *"yes*" to question #1, the Department will make an assessment of the nature, severity, and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" to determine if you are eligible for certification and whether conditions should be imposed.

2. Do you **currently** use chemical substance(s) in any way which impairs or limits your ability to provide EMS with reasonable skill and safety? If *"yes",* please explain. ☐ ☐

   "Currently" means recently enough so that the use of chemical substance(s) may have an ongoing impact on one's functioning as a certified EMS provider, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, in addition to those taken by way of a valid prescription for legitimate medical purposes in accordance with the prescriber's direction.

3. Are you **currently** engaged in the *illegal use* of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of controlled substances may have an ongoing impact on your ability to function as a certified EMS provider, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances not taken in accordance with the directions of a licensed healthcare practitioner.

OUT-OF-STATE APPLICATION (continued)

	Yes	No
4. Have you ever been diagnosed as having, or have you ever been treated for: Pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐

"Pedophilia" means: An unnatural desire for sexual relations with children.

"Exhibitionism" means: An abnormal impulse that causes one to expose the genitals to one of the opposite sex.

"Frotteurism" means: Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a non-consenting person.

"Voyeurism" means: Deriving sexual pleasure from observing the sexual activity of others.

If you must answer *"yes"* to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

	Yes	No
5. Have you ever been convicted, entered a plea of guilty, no contest (nolo contendre) or a plea of similar effect, or had prosecution or sentence deferred or suspended in connection with:		
a. The use or distribution of controlled substances or legend drugs?	☐	☐
b. A charge of a sex offense?	☐	☐
c. Any other crime other than *minor* traffic infractions? (For example: Driving While Intoxicated (DWI), Driving Under the Influence (DUI), and Reckless Driving).	☐	☐
6. Have you ever been found in any civil, administrative, or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. Committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. Violated any state or federal law or rule regarding the practice of a health care profession? If *"yes",* explain and provide copies of all judgments.	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If *"yes",* explain and provide copies of all judgments, decisions and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended or restricted by a state, federal or foreign authority? Have you ever surrendered such credential to avoid, or in connection with, an action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
10. Have you previously provided the Department of Health with information regarding any *"yes"* answers?	☐	☐

PLEASE NOTE: If you have answered *"yes*" to any of the above questions, you must submit a brief written statement and all relevant documents with this portion of the application. Please do not *re-send* documents which you have previously provided to this office to explain any "yes" answers.

APPLICANT STATEMENT: (This portion must be signed by the applicant)

"I hereby affirm and declare that the above information is true and correct, and that any fraudulent entry may be considered sufficient cause for rejection or subsequent revocation of my certification."

Applicant's original signature only **Date**

Phone #

NOTE: Part D, pages 3 and 4 of this application is good for a period of 6 months from date the applicant signs the form.

Department of Health, *Office of Emergency Medical Services & Trauma System*, P.O. Box 47853, Olympia WA 98504-7853

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Washington State Department of Health
Office of Emergency Medical Services And Trauma System
Licensing and Certification Section
Post Office Box 47853
Olympia WA 98504-7853
1-800-458-5281 or (360) 236-2845

Confirmation Form

PAGE 1 OF THIS FORM MUST BE COMPLETED BY APPLICANT.
APPLICANT MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC.

Please make copies if necessary, and complete the top portion (*please print*) and send to all state(s) where current EMS certifications or licenses are held. Please note that some states may charge a fee to complete this form.

AUTHORIZATION TO RELEASE INFORMATION TO THE WASHINGTON STATE OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA SYSTEM

NAME: _____
(Last Name, First Name, MI)

ALSO KNOWN AS: _____

MAILING ADDRESS: _____
(City, State, Zip)

WASHINGTON COUNTY WHERE YOU WILL BE EMPLOYED: _____

I hereby authorize the _____ EMS Agency (state to which you are sending this form) to furnish the information requested on Page 2 of this document.

Certification/License Number: _____ **EMS Level/Type:** _____

Social Security Number: _____ **Date of Birth:** _____
(Required under 42 USC 666 and Chapter 26.23 RCW) **(mm/dd/yyyy)**

Notary Public Seal

_____
*Applicant to sign in presence of Notary Public

Subscribed and sworn to before me this _____ *day of* _____, *20*___.

Notary Public for _____ *My Commission Expires* ____/____/____

OVER

_____
Notary Signature

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(10/03) [Supersedes all previous forms]

THIS SECTION TO BE COMPLETED BY THE STATE
CERTIFICATION OR LICENSURE AUTHORITY

Please complete the form below, and return to the address listed below.

1. Status of EMS certification/license:

EMS Level/Type of Certification: _____

Active ☐ Certification/License No: _____ Expiration Date: ____/____/____

Inactive ☐

2. Applicant received certification/license by:

Exam Yes ☐ No ☐

Reciprocity granted on certification from _____
(State, National Registry)

3. Has this person ever been disciplined, been placed on probation or had their certification/license suspended, revoked or denied by your agency, or by the supervising physician?

Yes ☐ No ☐

I hereby certify that the above is true and correct as recorded in the files of this office.

Signature	Name (print)
Title	Date
Agency Name	State

Department of Health, *Office of Emergency Medical Services & Trauma System*, P.O. Box 47853, Olympia WA 98504-7853
Office of Emergency Medical Services and Trauma System website: ***www.doh.wa.gov/hsqa/emtp/***

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(10/03) [Supersedes all previous forms]